WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (15)

07600

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

613 Columbia Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Alleg.

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 613 Columbia Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Alkire - Twin #2

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 18 '45

8. AGE: Years — Months — Days — If less than one day hrs. four min.

9. Birthplace Md

(Town, county, and state)

10. Usual occupation —

11. Industry or business —

FATHER 12. Name Charles A. Alkire

13. Birthplace Ridgeley W Va

MOTHER 14. Maiden name Bertie G. Watson

15. Birthplace Md

16. Informant Charles A. Alkire

Address Ridgeley W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 20 1945 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland Md

18. Funeral director Lois Steen Sex

Address Cumberland Md

19. Aug 20 1945 (Date rec'd by registrar) Hunter R. Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 18 1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18 1945 to Aug 18 1945 and that I last saw h. alive on Aug 18 1945

Immediate cause of death	DURATION
Still	
about 6 months in utero	
Due to Do not know	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. V. Deming M.D. M. D. or other

Address 25 Bedford St Date signed 8/19/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

07601

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (486)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Green Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Baltimore city

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 203 W. Franklin
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Margret Aramatsout

3. (b) Social Security Number none ✓

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widowed

6.(b) Name of husband or wife: Selau Aramatsout

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 29-1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72	6	27		

9. Birthplace: Gadentown - alleg Md.
(Town, county, and state)

10. Usual occupation: Asst Nurse

11. Industry or business: John Hopkins Hospital

FATHER
12. Name: Simon Aramatsout
13. Birthplace: Wales

MOTHER
14. Maiden name: unknown
15. Birthplace

16. Informant: Mrs Odela Stevens
Address: Frostburg, md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof aug 25-1945 (month) (day) (year)

Cemetery or ~~crematory~~: Cedar Bluff

Location: Annapolis, md

18. Funeral director: J. J. Dunn

Address: Frostburg md

19. 8-23 1945 (Date rec'd by registrar) Mrs. Nancy M. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 23 1945, at 12:05 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 1945, to August 23 1945 and that I last saw her alive on August 23 1945.

Immediate cause of death	DURATION
Carcinoma Uterus	2 yrs.
Due to arterio-sclerosis	
Chr. myocarditis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: X

Date of op.

Autopsy results: X

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: X Injured at work?

23. SIGNATURE: H. C. Diehl, M. D.
M. D. or other

Address: Frostburg, Md. Date signed 8/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

WITHIN CORPORATE LIMITS

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07602

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred: 314 Frederick St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 314 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Maggie A. Banks

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widowed

6.(b) Name of husband or wife: Ewing Banks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 9, 1870

8. AGE:

Years	Months	Days	If less than one day
74	11	22	..... hrs. ..... min.

9. Birthplace: Mineral Co. W. Va. (Town, county, and state)

10. Usual occupation: House wife

11. Industry or business: Own home

FATHER 12. Name: John Shuler

FATHER 13. Birthplace: Romney, W. Va.

MOTHER 14. Maiden name: Julie Ann Harpoe

MOTHER 15. Birthplace: Rawlings Station, Md.

16. Informant: Thomas T. Banks

Address: 512 Hill St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 4, 1945 (month) (day) (year)

Cemetery or crematory: Woodlawn Cemetary

Location: Cumberland, Md.

18. Funeral director: John L. Hafer

Address: Cumberland, Md.

19. Aug 4 1945 (Date rec'd by registrar) Walter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 1945 at 1:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Aug 1 1945 and that I last saw h— alive on July 30 1945

Immediate cause of death	DURATION
Thrombosis Embolism	
Due to: Arthritis deformans	20 yr
Due to:	
Other conditions: Ulcers on legs	10 yr

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. Alan E. Lemmon M.D. M. D. or other

Address: Cumberland Md. Date signed: Aug 4 1945

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1)

CERTIFICATE OF DEATH

07603

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 418 Seymour St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Flora Barnes

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Samuel E. Barnes
6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Feb 2, 1873

8. AGE: Years	Months	Days	If less than one day
72	6	4	..... hrs. ..... min.

9. Birthplace: Artemas, Pa.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: At Home
FATHER 12. Name: Samuel E. Barnes
13. Birthplace: Artemas, Pa.
MOTHER 14. Maiden name: Elizabeth Keel
15. Birthplace: Artemas, Pa
18. Informant: Mrs. Lula Pillow
Address: 305 Pa. Ave - Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 9 1945 (month) (day) (year)
Cemetery or crematory: Mt Herman Meth. Cemetery
Location: Near Cumberland, Md
18. Funeral director: John J. Haley
Address: Cumberland, Md.
19. Aug 9 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 6 19 45 at 5:54 P.M.
21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug 2 19 45 to Aug 6 19 45 and that I last saw her alive on Aug 6 19 45

Immediate cause of death	DURATION
Diabetes	1 year
Due to	
Due to	
Other conditions Arteriosclerosis	6 mos.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. H. Trevaskis M.D.
Address: Cumberland, Md M. D. or other
Date signed: Aug 8-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07604

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport, Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County Mineral

City or town Piedmont

(If outside city or town limits, write RURAL and give nearest town)

Street No. Childs Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Anderson Barricks

3.(b) Social Security Number 220-07-6176

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept 22, 1915

8. AGE: Years 29 | Months 10 | Days 19 | If less than one day ... hrs. ... min.

9. Birthplace Bloomington-Garrett-Md (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

FATHER 12. Name William A. Barrick

13. Birthplace Nat. Known

MOTHER 14. Maiden name Delphia "Barrick"

15. Birthplace Bloomington, Md

16. Informant Edgar Barrick

Address Westernport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 13, 1945 (month) (day) (year)

Cemetery or crematory Elmlon

Location Westernport, Md

18. Funeral director Edlesworth & Boal

Address Westernport Md

19. Aug 13 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11th, 1945, at about 1 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Fractured skull; crushed chest, (other major injuries)	killed instantly.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

... Date of op. ...

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of 8-11-45

Where did injury occur? near Westernport, Allegany Md.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) W.M.a. R.R. tracks

Means of injury struck by train Injured at work? no

23. SIGNATURE Prince H. Bowers, M.D.
M. D. or other

Address Cumberland, Maryland Date signed 8-11-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35)

CERTIFICATE OF DEATH

07605

Reg. Dist. No. 4

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years

Hospital, Institution, or street address where death occurred:
11. Rear East Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 11. Rear East Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: William Arthur Brandt

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ella Brandt

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 6, 1874

8. AGE: Years	Months	Days	If less than one day
71	6	23	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Machine Operator

11. Industry or business: City Of Lorain Ohio

FATHER
12. Name: Samuel Brandt
13. Birthplace: Allegany County

MOTHER
14. Maiden name: Anna Breashear
15. Birthplace: Allegany County

16. Informant: W. Clive Brandt

Address: 11. Rear East St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 1, 1945 (Date rec'd by registrar) Winter R. Beach M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29, 1945, at 12:01 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1, 1945 to Aug 29, 1945 and that I last saw h... alive on Aug 29, 1945

Immediate cause of death	DURATION
Coronary Occlusion	
Due to Heart	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. C. Brandt M. D. or other

Address: Cumberland Date signed: 8/30/45

WITHIN CORPORATE LIMITS

DR. C.L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21-0)

CERTIFICATE OF DEATH

07606

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINA County HAMPSHIRE
City or town POINTS
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME LENORA A. BURKETT

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	CHILD Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DEC. 18 1931

8. AGE: Years	Months	Days	If less than one day
13	7	27	..... hrs. ..... min.

9. Birthplace WEST VIRGINIA Points
(Town, county, and state)
10. Usual occupation STUDENT
11. Industry or business
FATHER 12. Name JAMES. H. BURKETT
13. Birthplace WEST VIRGINIA
MOTHER 14. Maiden name MAE BROWN
15. Birthplace WEST VIRGINIA
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 16, 1945 (month) (day) (year)
Cemetery or crematory Wesley Chapel
Location Points W, Va.
18. Funeral director P.E. Thrush & Sons
Address Romney W. Va.
19. Aug 16, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 14 19 45, at 4:15 A.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June — 19 45, to Aug 14 19 45
and that I last saw her alive on Aug 13 19 45

Immediate cause of death	DURATION
Uremia Endocarditis	1½ yr
Due to	
Acute Arthritis	2 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D.
M. D. or other
Address Cumberland Md Date signed 8-14-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

DR. REYNOLDS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (161-a)

CERTIFICATE OF DEATH

07607

★ Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County GARRETT
City or town KITZMILLER
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME BABY BOY BURRELL

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUGUST 17, 1945

8. AGE: Years	Months	Days	If less than one day
		1	hrs. ..... min.

9. Birthplace CUMBERLAND, MD.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name WILBUR BURRELL
13. Birthplace GEORGIA

MOTHER
14. Maiden name VIOLET GOLLER
15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/19/45 (month) (day) (year)
Cemetery or crematory I.O.O.F. Cemetery
Location Elk Garden, W. Va.

18. Funeral director O.F.Sharpless
Address Blaine, W. Va.

19. Aug 19 1945 (Date rec'd by registrar) Hunter A Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 18 1945 at 12:05 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 17/45 1945 to Aug 18 1945
and that I last saw h[illegible] alive on Aug 18/45 1945

Immediate cause of death Prematurity
Congenital debility
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas L Reynolds MD M. D. or other
Address Cumberland Md Date signed Aug 18/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

07608

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 42 years

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Howard St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Clarence B. Cain

3.(b) Social Security Number: 214-05-7023

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Edith "Thompson" Cain

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): December 6, 1876

8. AGE:	Years	Months	Days	If less than one day
	68	8	8	..... hrs. ..... min.

9. Birthplace: Berkley Springs, W. Va. (Town, county, and state)

10. Usual occupation: Gas Station attendant.

11. Industry or business

FATHER — 12. Name: James T Cain

FATHER — 13. Birthplace: Berkeley Springs, W. Va.

MOTHER — 14. Maiden name: Mary Harden

MOTHER — 15. Birthplace: Berkeley Springs, W. Va.

16. Informant: Mrs. Anna Cain

Address: 32 Howard St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 18, 1945 (month) (day) (year)

Cemetery or crematory: Green Way

Location: Berkley Springs, W. Va.

18. Funeral director: John J. Haley

Address: Cumberland, Md.

19. Aug. 17 1945 (Date rec'd by registrar) Walter K. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 14 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 11 1940, to Aug 14 1940, and that I last saw him alive on Aug 14 1940.

Immediate cause of death: Mitro. Carcinoma and Hypertension — (DURATION)

Due to: (DURATION)

Due to: (DURATION)

Other conditions: (DURATION)

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: C. F. W. Snyder M. D. or other

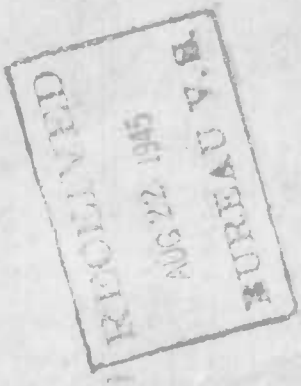
Address: Cumberland Md. Date signed 8-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Please call
65 when signed



WITHIN CORPORATE LIMITS

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07609

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 2 mos

Hospital, institution, or street address where death occurred: 903 Harding Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 903 Hardmg Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Albert B Cessna

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Molly Sommerlatt

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): July 5 1870

8. AGE: Years 75 | Months 1 | Days 23 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Centreville Pa.
(Town, county, and state)

10. Usual occupation: Road Foreman

11. Industry or business: Allegany Co.

FATHER
12. Name: Francis Marion Cessna
13. Birthplace: Pa.

MOTHER
14. Maiden name: Hardman
15. Birthplace: Pa.

16. Informant: Mrs A B Cessna
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 30 45 (month) (day) (year)

Cemetery or crematory: County Institution Cem

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Aug. 30 19 45 (Date rec'd by registrar) Walter R. Wantz, M.A. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 28 1945, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 19 45 to Aug 28 19 45 and that I last saw him alive on Aug 23 19 45

Immediate cause of death	DURATION
Cerebral Hemorrhage	8 mos
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) ____ (County) ____ (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: R. A. Trewaskis, M.D. M. D. or other

Address: Cumberland, Md Date signed: Aug 29-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

02610

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54 yrs.
Hospital, institution, or street address where death occurred: 714 Sylvan Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 714 Sylvan Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edward R. Clark

3.(b) Social Security Number 220-10-5392

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Idella Shinkroll
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) July 23 1891

8. AGE: Years 54 Months 1 Days 3 If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation Plumber

11. Industry or business

FATHER 12. Name Edward Allen Clark
13. Birthplace Md.

MOTHER 14. Maiden name Emma Rossmond
15. Birthplace Md.

18. Informant Mrs. Idella Clark.
Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29 1945 (month) (day) (year)
Cemetery or crematory St. Peter & Pauls Cem.
Location Cumberland
18. Funeral director Lowis Stein Inc.
Address Cumberland

19. Aug 28, 1945 (Date rec'd by registrar) Wintey R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 26th., 1945, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op.....

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Bruce M. Brason, M.D.
M. D. or other
Address Cumberland, Maryland Date signed 8-26-45

WHITE — CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (52)

CERTIFICATE OF DEATH

07611

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21. Days

Hospital, institution, or street address where death occurred:
429. Broadway

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 722 Glenmore St
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marion Elizabeth Cook

3.(b) Social Security Number: 214-05-6029

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles Herman Cook

6.(c) If alive, give age: 41 years

7. Birth date of deceased (mo., day, yr.): August 1, 1905

8. AGE: Years	Months	Days	If less than one day
40	0	14	...hrs. ...min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER — 12. Name: John G. Lester

FATHER — 13. Birthplace: Baltimore, Md.

MOTHER — 14. Maiden name: Elizabeth Beatty

MOTHER — 15. Birthplace: Wilmington, Del

16. Informant: Charles H. Cook

Address: 722. Glenmore St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 19/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoluem

Location: Cumberland, Md.

18. Funeral director: William H. Kicht

Address: Cumberland, Md.

19. Aug 18 1945 (Date rec'd by registrar) Hunter R. Scott, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15, 1945 at 9-45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-8- 1945, to 8-15- 1945 and that I last saw h.. alive on 8-11- 1945

Immediate cause of death	DURATION
Carcinoma of Bladder	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: none Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Howard L. Folson M.D. M. D. or other

Address: Cumberland, Md. Date signed 8-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

07612

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 Days
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 15 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: W.VA. County: HAMPSHIRE
City or town: GREEN SPRING (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: EDNA COSNER

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: GILBERT E. COSNER
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): NOVEMBER 23 1882

8. AGE: Years: 62 | Months: 9 | Days: 2 | If less than one day: hrs. min.

9. Birthplace: W. VA. (Town, county, and state)
10. Usual occupation: House Work
11. Industry or business: Own House

FATHER
12. Name: JASPER CUTLIP
13. Birthplace: W.VA.

MOTHER
14. Maiden name: SARAH THRASH
15. Birthplace: W Va

16. Informant: Gilbert E. Cosner
Address: Green Spring W Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/28/45 (month) (day) (year)
Cemetery or crematory: Forest Glenn Cem.
Location: Green Spring W Va

18. Funeral director: P.E. Thrush & Son
Address: Romney, W Va

19. Aug. 28, 1945 (Date rec'd by registrar) Winter R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 25, 1945 19... at 8:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 10, 1945, to Aug 25 1945
and that I last saw h.e. alive on Aug 25, 1945

Immediate cause of death	DURATION
Acute cholecystitis &	
Calculi the Liver	3 wks.
Due to	
Due to	
Other conditions Acute cardiac failure	1 day

(Include pregnancy within 3 months of death)

Major findings of operations: Cholecystectomy
Date of op. 8-13-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: D. G. Moore M.D. M. D. or other
Address: Medical Bldg Date signed 8-25-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MA)

07613

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? - 30 yrs.
Hospital, institution, or street address where death occurred:
43 Offutt St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 43 Offutt St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Tracie V. Crabtree

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John Crabtree
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 3, 1882

8. AGE: Years	Months	Days	If less than one day
63	4	5	hrs. ..... min.

9. Birthplace: Green Ridge Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Jacob Thomas
13. Birthplace: Md

MOTHER
14. Maiden name: Mary McAtee
15. Birthplace: Md.

16. Informant: John Crabtree
Address: 43 Offutt St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetary
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, MA

19. Aug. 11, 1945 (Date received by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 8 1945, at 8 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 7 1944 to Aug 8 1945
and that I last saw h-- alive on Aug 7 1945

Immediate cause of death	DURATION
(a) Coronary Thrombosis	3 days
Due to: Branchial asthma	20 yrs
Due to: Chronic Pleurisy	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Thos H. Frantz M. D. or other
Address: Cumberland Md Date signed: 8/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 8330

CERTIFICATE OF DEATH

07614

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred: 653 Baker

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(If newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 653 Baker St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mary M. Crawford.

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: David A Crawford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 19 1882

8. AGE: Years 62 | Months 10 | Days 6 | If less than one day ..... hrs. ..... min.

9. Birthplace: Ohio (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: John Albright

13. Birthplace: Ohio

MOTHER 14. Maiden name: Martha

15. Birthplace: Ohio.

16. Informant: Mrs. Sylvia Brant

Address: La Vale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 29 '45 (month) (day) (year)

Cemetery or crematory: Hillcrest Mem.

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Aug 28 1945 (Date rec'd by registrar) Witter R. Mantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 25 1945 at 5 30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/23 1945 to 8/25 1945 and that I last saw h.. alive on 8/25 1945

	DURATION
Immediate cause of death: apoplexia	
Due to: arterial hypertension	
Due to:	
Other conditions: /	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Elizabeth Briggs, M.D. M. D. or other

Address Long, Md. Date signed 8/28/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

07615

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred: 625 N. Centre St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 625 N. Centre St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Robert B Cunningham
3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie Haldeman
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 21 1873

8. AGE:

Years	Months	Days	If less than one day
72	5	15	hrs. min.

9. Birthplace: Sand Patch, Pa. (Town, county, and state)
10. Usual occupation: R.
11. Industry or business: Retired — 15 yrs
12. FATHER — Name: Harrison Cunningham
13. FATHER — Birthplace: Somerset Co, Penna.
14. MOTHER — Maiden name: Delilah Baer
15. MOTHER — Birthplace: Somerset Co, Penna
16. Informant: Bro H. M. O'Rourke.
Address: Cumberland.
17. Burial (Burial, cremation, or removal, which?) Date thereof: Aug 8 45 (month) (day) (year)
Cemetery or crematory: St Patricks Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc.
Address: Cumberland.
19. Aug 8, 1945 (Date rec'd by registrar) Winter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 6 1945, at 7 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15 1945 to Aug 6 1945 and that I last saw h alive on Aug 6 1945

Immediate cause of death	DURATION
Organic Heart Disease, Pulmonary Embolism	24 hrs
Due to: Pulmonary Thrombosis	24 hrs
Due to: Chronic Nephritis	24 hrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos A Thomas M. D. or other
Address: Cumberland Md Date signed: 8/6/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

87616

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 mos 2 weeks

Hospital, Institution, or street address where death occurred: Sylvan Retreat.

How long in hospital or institution? 4 mos 2 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Maryland County Allegany

City or town Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No. East Main St. (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Janet B. Ritchie Cuthbertson

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: William M. Cuthbertson

6.(c) If alive, give age 71 years

7. Birth date of deceased (mo., day, yr.) February 7, 1872

8. AGE: Years 73 | Months 5 | Days 25 | If less than one day ... hrs. ... min.

9. Birthplace Fifeshire, Scotland (Town, county, and state)

10. Usual occupation Housework

11. Industry or business Own Home

FATHER — 12. Name Thomas L. Ritchie

FATHER — 13. Birthplace Scotland

MOTHER — 14. Maiden name Margery Robertson

MOTHER — 15. Birthplace Scotland

16. Informant Mrs. W. Cuthbertson

Address Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 15, 1945 (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing Md.

18. Funeral director M. Eichhorn

Address Lonaconing, Md.

19. Aug 13 1945 (Date rec'd by registrar) Wm. F. Dent, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-11 1945, at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-23 1945, to 8-11 1945 and that I last saw h[illegible] alive on 8-11 1945

	DURATION
Immediate cause of death Cerebral Hemorrhage	
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE W. F. Williams M. D. (or other)

Address Cumberland Date signed 8-13-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B/a)

CERTIFICATE OF DEATH

07617

★ Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 mos.

Hospital, Institution, or street address where death occurred:

111 Pennsylvania Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 111 Pennsylvania Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Roland Thomas Dayton

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Sarah Va Long

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 25 1867

8. AGE: Years	Months	Days	If less than one day
78	2	4	..... hrs. ..... min.

9. Birthplace Keyser W. Va. (Town, county, and state)

10. Usual occupation Ry. Engineer

11. Industry or business Retired

FATHER 12. Name John Thomas Dayton

FATHER 13. Birthplace W. Va.

MOTHER 14. Maiden name Mary Ellen Greenwade

MOTHER 15. Birthplace Md.

16. Informant H. L. Dayton

Address Ridgley W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 1 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Aug 31 1945 (Date rec'd by registrar) Hunter R. Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945, at 6 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 1945, to Aug. 29 1945

and that I last saw h.. w.. alive on Aug. 29 1945

	DURATION
Immediate cause of death Chronic myocarditis	5 yrs
Due to Chronic Nephritis	4 yrs
Due to Arteriosclerosis	
Due to Chronic Hypertrophy of Prostate	6 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE H C W Evason M.D. M. D. or other

Address 6 Union St Cumberland Md. Date signed 8/30/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

07618

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (746)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 mo 20 days

Hospital, Institution, or street address where death occurred: Memorial Hospital.

How long in hospital or Institution? 1 mo. 2 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Pa. County Fayette.

City or town Markleysburg Pa.
(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D #1
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME Charles Deal

3.(b) Social Security Number ?

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Apr 12, 1909

8. AGE:

Years	Months	Days	If less than one day
36	4	5	..... hrs. ..... min.

9. Birthplace Addison Township, Pa
(Town, county, and state)

10. Usual occupation Truck Driver

11. Industry or business Lumber

FATHER 12. Name John Deal

13. Birthplace Addison Township, Pa

MOTHER 14. Maiden name Florence Barr

15. Birthplace Addison Township, Pa

16. Informant H. B. Rushelarger

Address Addison, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19, 1945 (month) (day) (year)

Cemetery or crematory St Paul Cemetery

Location Addison Township, Penna.

18. Funeral director John J Hafer

Address Cumberland, Md.

19. Aug 17 1945 Witter R. Frantz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-17-1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1945, to Aug. 17 1945 and that I last saw h[illegible]ive on Aug. 17 1945

Immediate cause of death	DURATION
(a) Uremia	
Due to (b) Pyelonephritis	2 mos.
Due to (c) —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 8-17-45

WITHIN CORPORATE LIMITS

BR. C. L. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (119a)

CERTIFICATE OF DEATH

07619

Reg. Dist. No. 4

1. PLACE OF DEATH
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town 303 MARYLAND AVE.
(If outside city or town limits, write RURAL and give nearest town)
Street No. CUMBERLAND, MD.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
RICHARD Daniel FOGLE

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 26, 1944

8. AGE: Years | Months 10 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND, Cumberland, Allegany Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name DANIEL FOGLE
13. Birthplace WEST VIRGINIA

MOTHER
14. Maiden name CLARA McCRAY
15. Birthplace PENNSYLVANIA

16. Informant DANIEL FOGLE
Address 303 MARYLAND AVE, CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 6, 1945 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Cumberland, Md.

18. Funeral director Harvey W. Zeigler
Address Hyndman, Pa.

19. Aug 6 1945 (Date rec'd by registrar) Victor R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 4, 1945 at 2:14 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1945 to Aug 4th 1945 and that I last saw him alive on Aug 3rd 1945

Immediate cause of death	DURATION
Acute Flaccid Poliomyelitis	1 wk
Due to Intestinal Paralysis	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D. M. D. or other
Address Cumberland Md Date signed 8-4-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 9

Ler. per Lane
17620

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rose Gaudio

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Michael Gaudio

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 29, 1882

8. AGE:

Years	Months	Days	If less than one day
63	1	25	..... hrs. ..... min.

9. Birthplace: Caserta Italy (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Home

FATHER
12. Name: Luigi Casanova
13. Birthplace: Italy

MOTHER
14. Maiden name: Teresa Desantis
15. Birthplace: Italy

18. Informant: Mrs. Matilda Gaudio

Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27 1945 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 8-27 1945 (Date rec'd by registrar) Mrs Mary H Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 24 1945 at 12 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1 1945, to Aug 24 1945 and that I last saw h alive on Aug 23 1945

Immediate cause of death	DURATION
(a) Chr Myocarditis	Several months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: W M Lane Jr MD M. D. or other

Address: Frostburg Md Date signed Aug 26 1945

WITHIN CORPORATE LIMITS

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (39)

CERTIFICATE OF DEATH

07621

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Washington St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Carmela R Gigliotti

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Frank F Gigliotti

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 6 1905

8. AGE: Years 40 | Months 2 | Days 9 | If less than one day ..... hrs. ..... min.

9. Birthplace Italy (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business at Home.

FATHER 12. Name Rosacco, Anthony

13. Birthplace Italy

MOTHER 14. Maiden name Gerillo, Gaetana

15. Birthplace Italy

16. Informant Frank F Gigliotti

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 18 45 (month) (day) (year)

Cemetery or crematory St Peters & Paul Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Aug 17 19 45 Winter K. Frantz M.D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 45, at 7 P. M.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Aug 10 19 45 to Aug 15 19 45

and that I last saw h.. alive on Aug 13 19 45

Immediate cause of death	DURATION
Cancer of breast	6 mos.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. F. Trevaskis M.D.

M. D., or other

Address Cumberland, Md Date signed Aug 19-45

WITHIN CORPORATE LIMITS

DR. REYNOLDS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

07622

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 11 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town ACCIDENT
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME BABY BOY GLASS

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	INFANT

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUG. 4, 1945

8. AGE: Years	Months	Days	If less than one day
			11 hrs. ..... min.

9. Birthplace CUMBERLAND, ALLEGANY CO. MARYLAND
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name CHRIS GLASS

13. Birthplace MD.

MOTHER — 14. Maiden name FERNE SMITH GLASS

15. Birthplace MD.

16. Informant Memorial Hospital

Address Cumberland, Md.

17. Cremation (Burial, cremation, or removal. Which?) Date thereof Aug. 4 1945 (month) (day) (year)

Cemetery or crematory MEMORIAL HOSPITAL

Location CUMBERLAND, MD.

18. Funeral director Same

Address

19. Aug. 4 1945 (Date rec'd by registrar) Winter R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 4 1945 at 11 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h... alive on Aug 4/45 19.....

Immediate cause of death	DURATION
Prematurely	
Due to Congenital Atelectasis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Gregg Reynolds M.D.
M. D. or other

Address Cumberland, Md. Date signed Aug 4/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (35a)

07623

CERTIFICATE OF DEATH

State File No. C 97 SEP 10 1945

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Years 7 Months

Hospital, institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 3 Years 7 Months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 231. Pear St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Nettie Graham

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

8.(b) Name of husband or wife: Charles C. Graham

8.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): September 1, 1868

8. AGE: Years	Months	Days	If less than one day
77	8	8	....hrs. ....min.

9. Birthplace: Mt. Savage, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER 12. Name: Benjiman Norris

FATHER 13. Birthplace: Sandy Hook, Pa

MOTHER 14. Maiden name: Anna Jacobs

MOTHER 15. Birthplace: Unknown

16. Informant: Charles C. Graham

Address: 231. Pear St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Sept. 1, 19 45 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 19 45, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 20 19 44 to Aug. 29 19 45 and that I last saw h[illegible] alive on S. 29. 19 45

	DURATION
Immediate cause of death: Cerebral Hemorrhage	Two Days
Due to: Generalized Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op. None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed 8-30-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS
Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07624

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 56 years
Hospital, Institution, or street address where death occurred:
131 Grand Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 131 Grand Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Ann "Goldizen" Gross

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife James A. Gross
6.(c) If alive, give age 88 years

7. Birth date of deceased (mo., day, yr.) October 19, 1858

8. AGE:	Years	Months	Days	If less than one day
	86	9	16	..... hrs. ..... min.

9. Birthplace Oldfields, W. Va.
(Town, county, and state)
10. Usual occupation Housewife
11. Industry or business Own home
FATHER 12. Name William Goldizen
13. Birthplace W. Va.
MOTHER 14. Maiden name Rhoda Hardy
15. Birthplace W. Va.
16. Informant Nellie Frame
Address 131 Grand Ave.
17. Burial (Burial, cremation, or removal. Which?) Date thereof August 7 1945 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland
18. Funeral director John T. Hoffman
Address Cumberland, Md.
19. Aug. 7 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 5 1945, at 5:15 A M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Mar. 45, to Aug. 5 45
and that I last saw him alive on Aug. 4 45

Immediate cause of death	DURATION
Cerebral Thrombosis	5 hrs
Due to Myocarditis	yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Geo. E. Lemmon M. D. or other
Address Cumberland Date signed Aug 6, 1945

WITHIN CORPORATE LIMITS

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (31-C)

CERTIFICATE OF DEATH

07625

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 Days

Hospital, Institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 20 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Corrigianville
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Anna Belle Hamburg

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 12 1927

8. AGE: Years	Months	Days	If less than one day
18	0	17	...hrs. ...min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Unemployed

11. Industry or business

FATHER
12. Name: Andrew Hamburg
13. Birthplace: Austria

MOTHER
14. Maiden name: Stella Day
15. Birthplace: Thomas, W. Va.

16. Informant: Mrs. Andrew Hamburg
Address: Corriganville, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/1/45 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 31, 19 45 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 29 19 45 at ... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 14 19 45 to Aug 29 19 45 and that I last saw h.. alive on Aug 28 " 19 45

Immediate cause of death	DURATION
Chronic Nephritis	1 year
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. N. Trevaskis, M.D.
M. D. or other

Address: Cumberland, Md Date signed: Aug 29-45

WITHIN CORPORATE LIMITS

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

07626

★ Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 75 yrs.

Hospital, institution, or street address where death occurred: 114 Park St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Park St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mary Hammersmith

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Sebastian Hammersmith

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 7 1857

8. AGE: Years: 93 | Months: 4 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Bavaria, Germany
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER — 12. Name: Joseph Schwendner

FATHER — 13. Birthplace: Germany

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: "

18. Informant: Mrs Mary Landis

Address: 114 Park St

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 3 1945 (month) (day) (year)

Cemetery or crematory: St Peter & Paul

Location: Together St Cumberland

18. Funeral director: Geo's Sons Inc

Address: Cumberland Maryland

19. Sept. 1 19 45 (Date rec'd by registrar) Walter R. Bantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 31 19 45 at 3 30 P M

I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-6-45 19 to 8-31-45 19

and that I last saw her alive on 8-31-45 19

Immediate cause of death	DURATION
Cerebral apoplexy	1 wk.
Due to	
Due to	
Other conditions	

(include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: C L Zimmerman M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 9-1-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

07627

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 36 yrs.

Hospital, Institution, or street address where death occurred:
Sylvan Retreat

How long in hospital or institution? 9 months.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 Riehl Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lida Anderson Harlan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 4, 1875

8. AGE: Years 70 | Months 1 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace Philadelphia Pa.
(Town, county, and state)

10. Usual occupation Retired Laundry Worker

11. Industry or business Cumberland Laundry

FATHER 12. Name Thomas W. Halan

13. Birthplace Philadelphia Pa.

MOTHER 14. Maiden name Eliza Anderson

15. Birthplace Philadelphia, Pa.

16. Informant Ormand W. Howe

Address 517 Forester Ave.

17. Burial Date thereof Aug 5 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J. Hafer

Address Cumberland, Md.

19. Aug. 4, 1945 Winter R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8-3- 1945, at 5 a.m.

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from 1.1.44 to 8.3.45 and that I last saw h alive on 8-1- 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. F. Williams M. D. or other

Address Cumberland Date signed 8-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (85)

CERTIFICATE OF DEATH

07628

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred:

412 Central Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 412 Central Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Margaret Jane Harris

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 9 1931

8. AGE:	Years	Months	Days	If less than one day
	13	11	28	hrs. min.

9. Birthplace Job, W. Va. (Town, county, and state)

10. Usual occupation School

11. Industry or business

FATHER 12. Name Floyd Harris

13. Birthplace Grafton, W. Va.

MOTHER 14. Maiden name Margaret Cunningham

15. Birthplace Pendleton Co. W. Va.

16. Informant Floyd Harris

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 9, 1945 (month) (day) (year)

Cemetery or crematory Rose Hill

Location Cumberland, Md

18. Funeral director John L. Storer

Address Cumberland, Md.

19. Aug 9 1945 (Date rec'd by registrar) Walter P. Trantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 7 1945 at 1:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Epilepsy	since age 6
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Prince H. Brown M.D. M. D. or other

Address Cumberland, Maryland Date signed 8-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

Torison

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-a)

CERTIFICATE OF DEATH

07629

★ Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pennsylvania County: Somerset
City or town: Meyersdale
(If outside city or town limits, write RURAL and give nearest town)
Street No. 349 Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Dr. Bradley H. Hoke

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Alice Lamar
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): December 8, 1871

8. AGE: Years	Months	Days	If less than one day
73	8	14	hrs. min.

9. Birthplace: Maryland, Frederick
(Town, county, and state)
10. Usual occupation: Physician
11. Industry or business
FATHER 12. Name: Samuel Hoke
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Sarah Hartman
MOTHER 15. Birthplace: Maryland
16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. BORIAL (Burial, cremation, or removal. Which?) Date thereof Aug 25 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olivet Cem
Location: Frederick, Md.
18. Funeral director: Stanley M Thomas
Address: Salisbury, Penna
19. Aug 27 1945 (Date rec'd by registrar) Winter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 22, 1945 at 7:05 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 1945 to Aug 22 1945 and that I last saw h[illegible] alive on Aug 22 1945
Immediate cause of death: Uremia — DURATION: 24 hrs
Due to: Following Transurethral Prostatic resection
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operation: Hypertrophied prostate
Date of op. Aug 6, 1945
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. M. Wilson M.D. or other
Address: Cumberland Md. Date signed 8-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

47630

Reg. Dist. No. 8

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing Md.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Hodgson's Clinic

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State X County Alleg

City or town Mich

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME House

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1945

8. AGE: Years	Months	Days	If less than one day
			3 hrs. min.

9. Birthplace Lonaconing Allegany Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Edward Junior House

FATHER 13. Birthplace Gilmore, Md.

MOTHER 14. Maiden name Alice Marie Muir

MOTHER 15. Birthplace Nikep, Md.

16. Informant Mrs. Edward House

Address Nikep Md.

17. Burial Date thereof Aug 14 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Oak Hill Cemetery

Location Lonaconing, Md.

18. Funeral director W. Eichham

Address Lonaconing, Md.

19. August 13 1945 D. E. Dunlop
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 12 1945, at 11 10 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 1945, to Aug 12 1945 and that I last saw h.. alive on Aug 12 1945

Immediate cause of death	DURATION
Premature birth	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Henry Jr. Hodgson M.D.
M. D. or other

Address Lonaconing, Md. Date signed Aug. 13 '45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07631

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
733 Hilltop Drive

How long in hospital or institution? 6 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 Pine Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Mathilda Imes

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Thomas Imes

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 8, 1876

8. AGE:	Years	Months	Days	If less than one day
	69	4	7	..... hrs. ..... min.

9. Birthplace: Cheneyville Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: William Northcraft
13. Birthplace: Cheneysville, Pa.

MOTHER
14. Maiden name: Nellie Wimmer
15. Birthplace: Clearville, Pa.

16. Informant: Elmer Northcraft
Address: Cheneyville, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 17 1945 (month) (day) (year)

Cemetery or crematory: Mt Zion Christian Church

Location: Near Cheneysville, Pa.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Aug 17 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 15 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1945, to Aug 15 1945, and that I last saw h alive on Aug 14 1945

Immediate cause of death	DURATION
Hypostatic Congestion of Lungs	3 days
Due to: Hypertension Heart Disease	1 yr
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: F. Allen G. Lemmon M.D.
M. D. or other

Address: Cumberland Md Date signed Aug 16 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Please call
65 when signed.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

07632

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town near Cumberland rural (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, institution, or street address where death occurred: Roberts Place - R#5

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State Md. County Allegany

City or town near Cumberland Rural (If outside city or town limits, write RURAL and give nearest town)

Street No. R#5 - Roberts Place (If rural, give LOCATION)

2.(a) If veteran, name war No

3.(a) FULL NAME Isaac Drummond Junkins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife (Smith) Junkins 6.(c) If alive, give age 73 years

7. Birth date of deceased (mo., day, yr.) March 9, 1861

8. AGE:

Years	Months	Days	If less than one day
84	4	29	..... hrs. ..... min.

9. Birthplace near Kitzmiller Garrett Co. Md. (Town, county, and state)

10. Usual occupation Merchant

11. Industry or business

FATHER 12. Name John Anderson Junkins

13. Birthplace near Kitzmiller, Md

MOTHER 14. Maiden name Keziah Kitzmiller

15. Birthplace Mineral Co. W. Va

16. Informant Mrs. I. D. Junkins

Address R#5 - Roberts Place - Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 10 1945 (month) (day) (year)

Cemetery or crematory I.O.O.F. Cemetery

Location Elk Gardens, W. Va

18. Funeral director Otha F. Shamplesss

Address Blaine, W. Va

19. Aug 10 1945 (Date rec'd by registrar) Hunter R. Trout M.S. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 8 1945, at 2:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 1945, to August 8 1945 and that I last saw h... alive on August 4 1945

Immediate cause of death	DURATION
Apoplectic Stroke	7 days
Due to arterial hypertension	Personal
Due to	yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. Brings M.D. M. D. or other

Address Lonaconing Md Date signed 8-9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS (Williams)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (45)

07633

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct and is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 years

Hospital, Institution, or street address where death occurred: Allegany Co. Infirmary

How long in hospital or institution? 10 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Hanover St. (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: George Dallas Kennedy, Sr.

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife: Alice Thompson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 18, 1866

8. AGE: Years	Months	Days	If less than one day
79	4	1	hrs. min.

9. Birthplace: Stormstown, Pa. (Town, county, and state)

10. Usual occupation: Telegrapher (Retired)

11. Industry or business: R. R. Co.

FATHER — 12. Name: David A. Kennedy

FATHER — 13. Birthplace: Pa.

MOTHER — 14. Maiden name: Martha L. Griffin

MOTHER — 15. Birthplace: Pa.

16. Informant: George D. Kennedy, Jr.

Address: 430 N. Mechanic, City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 22, 1945 (month) (day) (year)

Cemetery or crematory: Zion Memorial Park

Location: Cumberland Md

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Aug. 22, 1945 (Date rec'd by registrar) Wilbur F. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 20 1945 at 5 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 8 1945 to Aug 20 1945 and that I last saw h[illegible] alive on 8. 18 1945

Immediate cause of death	DURATION
Carcinoma	?
Due to: Bronchi	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 8-21-45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47)

CERTIFICATE OF DEATH

07634

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 59 yrs
Hospital, institution, or street address where death occurred: 307 Fort View Drive
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 307 Fort View Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Robert E King

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Caroline Shaffer
8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 19 1886

8. AGE: Years 59 | Months 1 | Days 22 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: Unemployment office

FATHER
12. Name: Alexander King
13. Birthplace: Md.

MOTHER
14. Maiden name: Mathilda Russell
15. Birthplace: Md.

16. Informant: Mrs. Caroline King
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 14, 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland Md.

18. Funeral director: Louis Stein Inc
Address: Cumberland Md.

19. Aug 14 1945 (Date rec'd by registrar) Hunter R Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 11 1945 at 6 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1 1943 to Aug 11 1945 and that I last saw him alive on Aug 11 1945

Immediate cause of death	DURATION
Primary Carcinoma of liver.	3 Mos?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: confirmed above diagnosis Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Lyle R. Everhart M.D.
M. D. or other
Address: 36 Greene St Date signed: 8/13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-d)

CERTIFICATE OF DEATH

07635

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Allegany

City or town: Near Flintstone Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Near Flintstone
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Blaine Eugene Kisamore

3.(b) Social Security Number None.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Maggie Nelson

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Nov 4, 1886

8. AGE:

Years	Months	Days	If less than one day
58	9	23	hrs. min.

9. Birthplace: Randolph County W. Va.
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: General Farming

FATHER
12. Name: Joah Kisamore
13. Birthplace: Pendleton County, W. Va.

MOTHER
14. Maiden name: Mary Harper
15. Birthplace: Pendleton County, W. Va.

16. Informant: Mrs Blaine E. Kisamore
Address: Flintstone Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 30, 1945 (month) (day) (year)

Cemetery or crematory: Nelson Cemetery

Location: Near Riverton W. Va.

19. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Aug 28 1945 (Date rec'd by registrar) Nina L. Bender Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27 1945 at 12:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8.9. 1945 to 8.27.1945 and that I last saw him alive on 8.24 1945

Immediate cause of death: Chronic Myocardial Degeneration

Due to:

Due to:

Other conditions: Benign hypertrophy of Prostate

(Include pregnancy within 3 months of death)

DURATION
?
"

Major findings of operations: None None
Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 8-28-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07636

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Frost Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Elizabeth Ellen Lancaster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Valery Lancaster

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 22 nd. 1877

8. AGE:

Years	Months	Days	If less than one day
68	6	19	..... hrs. ..... min.

9. Birthplace Frostburg, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Housekeeper

11. Industry or business

FATHER
12. Name Thomas W. Richardson
13. Birthplace England

MOTHER
14. Maiden name Nancy Miller
15. Birthplace North Branch, Alleg. Co., Md.

16. Informant Mrs. Eva Lancaster

Address 127 Frost Ave. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-13-1945 (month) (day) (year)

Cemetery or crematory Lapham Cemetery

Location Eckhart Jct. Md.

18. Funeral director Janet Draper

Address Frostburg, Md.

19. 8-11 1945 Jas. Haney M.R.R. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11 1945, at 7:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1942 to Aug 11 1945 and that I last saw h.. alive on 8/6 1945

Immediate cause of death Cardiovascular renal disease — DURATION 2 yrs

Due to Hypertension

Due to

Other conditions Diabetes mellitus — 20 yrs

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Hilda Fourlerbey M.D.
M. D. or other

Address Frostburg Date signed 8/11/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07637

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ✓
Hospital, Institution, or street address where death occurred:
Queen City Hotel
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.Va County Hampshire
City or town Radar.
(If outside city or town limits, write RURAL and give nearest town)
Street No. ✓
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Edgar A. Leatherman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife Ella Wright Leatherman
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 7 1883

8. AGE: Years	Months	Days	If less than one day
62	4	17	..... hrs. ..... min.

9. Birthplace Mineral County, W.Va
(Town, county, and state)
10. Usual occupation Farmer
11. Industry or business Orchardist

FATHER
12. Name Geo. T. Leatherman
13. Birthplace W.Va.

MOTHER
14. Maiden name Catherine E. Ludwick
15. Birthplace W.Va.

16. Informant Edgar J. Leatherman, Jr.
Address Radar. W.Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 27 1945 (month) (day) (year)
Cemetery or crematory Burlington. W.Va. Cem.
Location Burlington, W.Va.
18. Funeral director Louis Stein, Inc.
Address Cumberland, Md.

19. Aug. 24, 1945 (Date rec'd by registrar) Walter R. Brantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 24th., 1945, at 12:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. .....

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE. If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) ..... (County) ..... (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Russell H. Brantz M.D. M. D. or other
Address Cumberland, Maryland Date signed 8-24-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Outside of City Limits

E. Brp

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83)

CERTIFICATE OF DEATH

07638

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Long (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, Institution, or street address where death occurred: A St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Long (If outside city or town limits, write RURAL and give nearest town)

Street No. A St, Long (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Stanley Wm Logsdon

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret E. Helmstetter

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Nov 11, 1875

8. AGE:	Years	Months	Days	If less than one day
	69	8	25	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co. Md (Town, county, and state)

10. Usual occupation: Retired Blacksmith

11. Industry or business

FATHER

12. Name: William Logsdon

13. Birthplace: Mt. Savage, Md

MOTHER

14. Maiden name: Martha Whitlow

15. Birthplace: Cumberland, Md

16. Informant: Mrs. Margaret E. Logsdon

Address: Long, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8, 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John F. Hafer

Address: Cumberland, Md

19. Aug 8, 1945 (Date rec'd by registrar) Winter R. Bantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 6, 1945, at 3:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 12, 1945, to August 6, 1945, and that I last saw h[illegible] alive on 8/3 1945

Immediate cause of death	DURATION
(a) Epidermoidacia	
Due to (b) Arteriosclerosis	
Due to	
Other conditions /	

(Include pregnancy within 3 months of death)

Major findings of operations: /

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide / Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Elizabeth Long M.D. M. D. or other

Address: Long, Md. Date signed 8/7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (M-a)

07639

CERTIFICATE OF DEATH

★ Reg. Dist. No. 9

1. PLACE OF DEATH:
County Allegany
City or town Mt. Savage ~~Frostburg~~
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Few hours
Hospital, institution, or street address where death occurred: Miners Hospital Frostburg
How long in hospital or institution? 12½ hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Mt. Savage Rfd 3
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Osmond D. Armen F. Martin

3.(b) Social Security Number 215-10-1223

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Nora Davidson Martin
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) May 21, 1879

8. AGE: Years	Months	Days	If less than one day
66	3	0	..... hrs. ..... min.

9. Birthplace Connellsville Pa (Town, county, and state)
10. Usual occupation Carpenter
11. Industry or business
FATHER 12. Name John Martin
13. Birthplace Maryland
MOTHER 14. Maiden name Mary Trinity
15. Birthplace Maryland
16. Informant Mrs. Melvin Corley
Address Wellersburg, Pa.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 25, 1945 (month) (day) (year)
Cemetery ~~or crematory~~ Mt Savage Methodist
Location Mt. Savage, Md.
18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.
19. 8-23 1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 21st., 1945 at 8.30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Shock	12hrs.
	30 min.
Due to	
Due to	
Other conditions Comp., comminuted fracture left elbow joint.	

(Include pregnancy within 3 months of death)

Major findings of operations no operation Date of op.
Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 8-21-45
Where did injury occur? Mt. Savage, Allegany, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) industry
Means of injury fall from roof Injured at work? yes

23. SIGNATURE Pierce H. Brown, M.D.
Address Cumberland, Maryland M. D. or other
Date signed 8-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

07640

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 DAYS

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 5 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MD. County: ALLEGANY

City or town: CRESAPTOWN MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

MR ~~BERTRAM~~ MASON Bertrand A. Mason

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: CORA GUNNING Mason

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): October 12, 1893

8. AGE: Years	Months	Days	If less than one day
51	9	26	....hrs. ....min.

9. Birthplace: MD, ALLEGANY CO.
(Town, county, and state)

10. Usual occupation: DAIRY BUSINESS

11. Industry or business

FATHER
12. Name: JOSEPH MASON
13. Birthplace: Bedford Co. Pa.

MOTHER
14. Maiden name: Rose Mattingly
15. Birthplace: Bedford Co. Pa.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 11, 1945 (month) (day) (year)

Cemetery or crematory: St. Peter & Paul Cemetary

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Aug 9 19 45 (Date rec'd by registrar) Winter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUGUST 8 1945, at 6:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 3 1945, to Aug 8 1945, and that I last saw him alive on Aug 8 1945.

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: S. E. Cooper M. D. or other

Address: Cumberland Date signed: 8/9/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

07641 D

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cresaptown (Rural)

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?: —

Hospital, institution, or street address where death occurred: Braun Farm

How long in hospital or institution?:

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cresaptown,

(If outside city or town limits, write RURAL and give nearest town)

Street No.: McMullin Highway.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Russell Charles McBee

3.(b) Social Security Number: 219-03-8053

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Martha Lease

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Dec 28 1886

8. AGE:

Years	Months	Days	If less than one day
58	7	11	____ hrs. ____ min.

9. Birthplace: Cresaptown

(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Dairy Farming

FATHER

12. Name: Frank McBee

13. Birthplace: Md.

MOTHER

14. Maiden name: Marion Wright

15. Birthplace: Md.

16. Informant: Mrs. Eliz. McKenzie

Address: Cresaptown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 12 1945 (month) (day) (year)

Cemetery or crematory: Baptist Mt. Zion Cem.

Location: R.D. Fort Ashby on Keyser Rd.

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. 8/11 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 9 1945, at 6 45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 3 1942 to August 9 1945 and that I last saw h— alive on July 29 1945

Immediate cause of death: acute coronary occlusion

Due to: extension

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: for ... maintain ... many ... yrs.

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: L Bruce MD

M. D. or other

Address: Lonaconing Md. Date signed: 8-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

07642

Reg. Diat. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 76 yrs

Hospital, Institution, or street address where death occurred: Furnace Street

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Furnace Street

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: John McIntyre

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Nov. 4 1862

8. AGE: Years: 82 | Months: 9 | Days: 12 | If less than one day: ... hrs. ... min.

9. Birthplace: Lanarkshire, Scotland (Town, county, and state)

10. Usual occupation: Coal Miner - Retired

11. Industry or business: Georges Creek Coal & Iron Co.

FATHER — 12. Name: David McIntyre

FATHER — 13. Birthplace: Lanarkshire, Scotland

MOTHER — 14. Maiden name: Elizabeth Hartley

MOTHER — 15. Birthplace: Lanarkshire, Scotland

16. Informant: Mrs. John Scott

Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 18, 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: W. Eichhorn

Address: Lonaconing, Md.

19. Aug 16 1945 (Date rec'd by registrar) U.S. Official Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 15 1945, at 5-30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to — 19...

and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary occlusion — DURATION: Sudden death

Due to: —

Due to: —

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury — Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. (M. D. or other)

Address: Lonaconing, Md. Date signed Aug. 16 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07643

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred: 38 Elder St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 38 Elder St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Selvin Miller

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 10, 1871

8. AGE:

Years	Months	Days	If less than one day
73	10	23	hrs. min.

9. Birthplace Bedford County, Pa. (Town, county, and state)
10. Usual occupation Cement Contractor
11. Industry or business Contracting Business

FATHER
12. Name John M. Miller
13. Birthplace Bedford Co. Pa.

MOTHER
14. Maiden name Christina Miller
15. Birthplace Bedford Co. Pa.

16. Informant Mrs Emma Twigg
Address 38 Elder St - Cumberland, Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Aug 20, 1945 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland Md

18. Funeral director John J. Hafer
Address Cumberland Md

19. Aug 20 19 45 (Date rec'd by registrar) Vernon L. Grant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 19 45 at 10:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 17 19 45 to Aug. 17 19 45 and that I last saw him alive on Aug. 17 19 45

Immediate cause of death	DURATION
Intestinal Obstruction	
Due to (Probably Carcinoma)	Unk
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Clay S. Furrer M. D. or other
Address Cumberland Md Date signed Aug. 20, 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. ENFIELD

WITHIN CORPORATE LIMITS

M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-e)

CERTIFICATE OF DEATH

07644

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 6 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 215 HUMBIRD STREET
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME SHIRLEY L. MILLER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) MARCH 23, 1935

8. AGE: Years	Months	Days	If less than one day
10	4	22	..... hrs. ..... min.

9. Birthplace MARYLAND (Town, county, and stete)
10. Usual occupation STUDENT
11. Industry or business

FATHER
12. Name MILLER, HAROLD V.
13. Birthplace MD. Cumberland

MOTHER
14. Maiden name PRYOR, ADA L.
15. Birthplace Cumberland, Md

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 19, 1945 (month) (day) (year)
Cemetery or crematory Zion Memorial
Location Cumberland, Md
18. Funeral director John L. Hofer
Address Cumberland, Md.

19. Aug 19 1945 (Date rec'd by registrar) Winton R. Grant, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 15 1945 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15- 1945 to Aug 15- 1945
and that I last saw her alive on Aug 14- 1945

Immediate cause of death	DURATION
Cerebral Concussion	
Due to Auto accident	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of 8/15/45
Where did injury occur? Frostburg (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE A. C. Agnew M. D. or other
Address Cumberland Md Date signed 8/16/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

07645

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:
316 Harrison St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 316 Harrison St
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Emma Jane "Robosson" Morgan

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Charles Morgan

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): March 14, 1877

8. AGE:	Years	Months	Days	If less than one day
	68	5	10	..... hrs. ..... min.

9. Birthplace: Beans Cove, Pa.
(Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own home

FATHER
12. Name: John Robosson
13. Birthplace: ?

MOTHER
14. Maiden name: Caroline Deremer
15. Birthplace: Pa.

16. Informant: Earl R. Morgan
Address: R.r 5 Bloomsburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: August 27 1945 (month) (day) (year)

Cemetery or crematory: Prosperity Methodist Cemetery

Location: Near Cumberland

18. Funeral director: John J. Hoffer

Address: Cumberland, Md.

19. Aug. 27 1945 (Date rec'd by registrar) Wm. R. Dent M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 24 1945, at 6:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. .....

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. R. Dent M.D.
M. D. or other

Address: Cumberland, Maryland Date signed: 8-25-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07646

★ Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 99 Maple St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newboro infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 99 Maple St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas H. Morgan

3.(b) Social Security Number 220-10-4287

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Margaret Morgan
6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): September 3 1866

8. AGE: Years 78 | Months 11 | Days 12 | If less than one day: hrs. min.

9. Birthplace: Barberton Summit Cty. Ohio (Town, county, and state)
10. Usual occupation: retired - personnel
11. Industry or business: Celanese Corp.
12. FATHER Name: Thomas Morgan
13. FATHER Birthplace: Wales
14. MOTHER Maiden name: Eliza Lee
15. MOTHER Birthplace: England
16. Informant: Mrs. Myron Lehr
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: aug. 19-1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md.
18. Funeral director: J. J. Durst
Address: Frostburg Md.

18. 8-18 1945 Mrs. Stacey N. Roe Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 16 1945, at 5P M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from aug 1 1945, to Aug 16 1945 and that I last saw h alive on aug 15 1945

Immediate cause of death	DURATION
Fracture of C6 & 7 R P.T. Arm	16 Days
Due to	
Due to	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Aug 16 1945
Where did injury occur? Barberton (City or town) Ohio (County) (State)
Injured at home, farm, industry, public place (where?): Home of Butler
Means of injury: Fell Down steps Injured at work? No

23. SIGNATURE: Wm Lane Jr MD
M. D. or other
Address: Frostburg Md. Date signed: 8-17-45


RECEIVED
AUG 20 1945
BUREAU V. E.

WITHIN CORPORATE LIMITS

DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

07647

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No.: OLYMPIA HOTEL (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: JACOB NATHAN

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): AUG. 14 1861

8. AGE: Years: 84 | Months: — | Days: 7 | If less than one day: ____ hrs. ____ min.

9. Birthplace: BALTIMORE, MARYLAND (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Clerk.

FATHER — 12. Name: ISAAC NATHAN

FATHER — 13. Birthplace: GERMANY

MOTHER — 14. Maiden name: Bettie —

MOTHER — 15. Birthplace: GERMANY

16. Informant: Morris Rosenbaum

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 22 '45 (month) (day) (year)

Cemetery or crematory: Hebrew Friendship Cem

Location: Baltimore Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland

19. Aug 22, 1945 (Date rec'd by registrar) Walter R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: AUG. 21 1945, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1945 to Aug 21 1945 and that I last saw him alive on Aug 20 1945

Immediate cause of death	DURATION
Uremia	3 days
Due to: Chronic Nephritis	? ?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: ____ Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: [illegible] Date signed: 8-22-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1222)

CERTIFICATE OF DEATH

07648

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 61. Years

Hospital, Institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 210. Charles St

(If rural, give LOCATION)

2.(a) If veteran, name war: World War # 1.

3.(a) FULL NAME

Christopher Nimick

3.(b) Social Security Number

212-24-1608

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 19 1884

8. AGE: Years	Months	Days	If less than one day
61	6	0	hrs. min.

9. Birthplace: Cumberland, Allegany Co. Maryland (Town, county, and state)

10. Usual occupation: Retired Glass Worker

11. Industry or business: Potomac Glass Works

FATHER

12. Name: John Nimick

13. Birthplace: Germany

MOTHER

14. Maiden name: Elizabeth Reever

15. Birthplace: Germany

16. Informant: George M. Nimick

Address: 210. Charles St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/22/45 (month) (day) (year)

Cemetery or crematory: St Peter & Paul Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug 21 1945 (Date rec'd by registrar) Hunter Q Dent Jr Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 — 19 — 1945 at 8P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-11- 1945 to 8-19 1945

and that I last saw h= alive on 8-19- 1945

Immediate cause of death	DURATION
pulmonary edema	1 day
Due to: congestive heart failure	7 days
Due to: chronic myocard'l degen'n	years
Other conditions: diabetes mellitus	years 2 days

(Include pregnancy within 3 months of death)

Major findings of operations: strangulated left inguinal hernia Date of op. 8-14-45

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L H Brim M D (M. D. or other)

Address: Gym Md Date signed 8-20-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-2)

CERTIFICATE OF DEATH

07649

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 67 yrs

Hospital, institution, or street address where death occurred: 146 Hanover St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 146 Hanover St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillie B. Rice

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Lee M. Rice

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 29 1883

8. AGE:

Years	Months	Days	If less than one day
67	7	—	..... hrs. ..... min.

9. Birthplace Cumberland Md. (Town, county, and state)

10. Usual occupation Housewife.

11. Industry or business at Home.

FATHER

12. Name John W. Hallen

13. Birthplace Md.

MOTHER

14. Maiden name Elizabeth Roberts.

15. Birthplace Md.

16. Informant Miss. Elva Rice

Address 146 Hanover St., City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 1 45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc.

Address Cumberland.

19. Aug. 31 1945 (Date rec'd by registrar) Hunter R. Dantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 29 1945, at 9 40 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1944, to Aug 29 1945

and that I last saw h[illegible] alive on Aug 29 1945

Immediate cause of death Cerebral Hemorrhage

DURATION: 2 yrs

Due to Thrombosis Phlebitis

DURATION: 4 wks

Other conditions Hypertension

DURATION: Several years

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. A. Dwyer M.D.

M. D. or other

Address Cumberland Md. Date signed 8-30-45

WITHIN CORPORATE LIMITS Dr. Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-2)

CERTIFICATE OF DEATH

07650

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? XXXXX
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL,
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State W.VA. County MINERAL
City or town RIDGELEY
(If outside city or town limits, write RURAL and give nearest town)
Street No. RT. #1
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
RIFFLE, FRANCES ELIZABETH

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 7, 1945

8. AGE: Years	Months	Days	If less than one day
-	-	10	..... hrs. ..... min.

9. Birthplace W. VA.
(Town, county, and state)

10. Usual occupation INFANT

11. Industry or business

FATHER
12. Name RIFFLE, DONALD
13. Birthplace W.VA.

MOTHER
14. Maiden name MILLER, STELLA
15. Birthplace MD.

16. Informant MEMORIAL HOSPITAL
Address CUMBERL AND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 19 1945 (month) (day) (year)
Cemetery or crematory Abs Cem. MD
Location W. Va.

18. Funeral director Louis Stein Sons
Address Cumberland Md

19. Aug. 18 1945 (Date rec'd by registrar) Registrar
DR. C.L. OWENS

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 17, 1945 at 12:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Aug 17 1945
and that I last saw her alive on Aug 17 1945

Immediate cause of death	DURATION
Congenital	1 D
Due to Endocarditis	day
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. L. Owens M.D. M. D. or other
Address Cumberland Md Date signed 8-18-45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-C)

CERTIFICATE OF DEATH

07651 9

Reg. Dist. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Alleg.

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 min.

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Alleg.

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 1 Box 445 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Baby Boy Sivic (Premature)

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Single

8.(b) Name of husband or wife:

8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 8-19-45

8. AGE: Years | Months | Days | If less than one day: 15 min.

8. Birthplace: Frostburg Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business:

FATHER — 12. Name: Frank A. Sivic

FATHER — 13. Birthplace: Cleveland, Ohio.

MOTHER — 14. Maiden name: Cecelia E. Strain

MOTHER — 15. Birthplace: Eckhart-Mines Md.

18. Informant: Mrs. Frank A. Sivic

Address: Frostburg, Md. Rt. 1 Box 445

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 20 1945 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg Md.

18. Funeral director: Jacob Walker

Address: Frostburg Md.

19. 8-20 1945 Miss Nancy H. Rose Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 19 1945, at 7P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-19 1945, to 8-19 1945

and that I last saw him alive on 8-19 1945.

Immediate cause of death	DURATION
Premature birth 6½ mos.	
Due to: Marginal placenta praevia.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. C. Diehl M.D. M. D. or other

Address: Frostburg, Md. Date signed: 8/19/45

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

07652

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47. Years

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 7 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 216. Decatur St
(If rural, give LOCATION)

2.(a) If veteran, name war: World War 1.

3.(a) FULL NAME: Leroy R. Snyder

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male M	White	Married

6.(b) Name of husband or wife: Madeline Snyder

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): August 3 1897

8. AGE: Years	Months	Days	If less than one day
~~47~~ 47	11	22	....hrs. ....min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation: Properitor

11. Industry or business: Restrauant

FATHER 12. Name: John Snyder

13. Birthplace: Baltimore, Md.

MOTHER 14. Maiden name: Rose Haller

15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Leroy R. Snyder

Address: 216. Decatur St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/8/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug. 7, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 8 - 4 - 45, 19..., at 8.30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-29-45, 19..., to 8-4-45, 19...

and that I last saw him alive on 8-4-45, 19...

Immediate cause of death: Coronary Roberson — DURATION: 1 week

Due to:

Due to:

Other conditions: —

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury: ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: ..... Date signed 8-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-1)

CERTIFICATE OF DEATH

07653

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 126 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 126 South St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: James Albert Spicer

3.(b) Social Security Number: 217-10-6866

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Laura Feister Spicer

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 27, 1888

8. AGE: Years	Months	Days	If less than one day
56	8	29	hrs. min.

9. Birthplace: Keyser, W. Va. (Town, county, and state)

10. Usual occupation: Bottler

11. Industry or business: Malamphy Bottling Co.

FATHER — 12. Name: Joseph Spicer

FATHER — 13. Birthplace: Hampshire Co. W. Va.

MOTHER — 14. Maiden name: Mary Kerber

MOTHER — 15. Birthplace: Cumberland, Md.

16. Informant: Mrs. Laura Spicer

Address: 126 South St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 28, 1945 (month) (day) (year)

Cemetery or crematory: St. Mary's Burial Park

Location: Cumberland, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Aug. 27, 1945 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 25, 1945 at 2 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1945 to Aug. 1945

and that I last saw him alive on Aug. 14 1945

Immediate cause of death	DURATION
Chronic Valvular	5 yrs
Due to: Heart Disease	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John A. Lepper M.D. M. D. or other

Address: Hyndman Pa. Date signed: 8.25.45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

07654

Reg. Dist. No. 1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Near Oldtown (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Entire Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Near Oldtown (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mary Elizabeth Stallings

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Tolbert Stallings
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): May 18, 1857

8. AGE: Years	Months	Days	If less than one day
88	3	2	... hrs. ... min.

9. Birthplace: Oldtown Allegany Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Charlie Stallings
13. Birthplace: Maryland

MOTHER
14. Maiden name: Naomi Twigg
15. Birthplace: Maryland

16. Informant: Mrs J. W. Ager
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 22, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Olive (Church Cem.)
Location: Near Oldtown Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. 8/21/45 (Date rec'd by registrar) Mrs C A Stanholt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 20 1945, at 2:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 13 1945, to ... 19..., and that I last saw h... alive on August 13, 1945

Immediate cause of death	DURATION
Cardiac Failure	?
Due to Probable Diabetes Mellitus	
Due to Old age	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Dr. A. A. Seibel D.O. M. D. or other
Address: Penn Penn, W. Va. Date signed: 8-20-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07655

★ Reg. Diat. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: St. Mary's Parsonage (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: Annie E. Ravenscraft Stamp

3. (b) Social Security Number:

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

B.(b) Name of husband or wife: Peter Stamp

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): July 24, 1874

8. AGE: Years: 71 Months: 1 Days: 3 If less than one day: hrs. min.

9. Birthplace: Lawson Allegany County Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER 12. Name: Roland Dayton Ravenscraft

13. Birthplace: Unknown

MOTHER 14. Maiden name: Martha Ann Lawson

15. Birthplace: Maryland

16. Informant: Mrs. Albert Grindle

Address: Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 30, 1945 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. August 28 1945 (Date rec'd by registrar) Dyke Dan Tyler Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 27 1945, at 3 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19 to — 19

and that I last saw him alive on — 19

Immediate cause of death: Coronary Occlusion — DURATION: Sudden Death

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

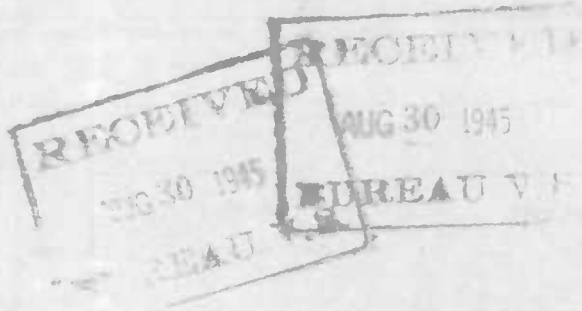
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson by W M. D. or other

Address: Lonaconing Md Date signed: Aug 28 45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AUG 30 1945
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L. Brings

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

07656

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Rout 5 Cumberland, Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, Institution, or street address where death occurred:
Potomac Park, Rt. 5, Cumberland, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md County Allegany

City or town Rt 5 Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Route 5
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Gabriel J. Stevanus

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Widowed

6.(b) Name of husband or wife Rebecca Jane "Keefer" Stevanus

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) August 17, 1862

8. AGE:	Years	Months	Days	If less than one day
	82	11	27	..... hrs. ..... min.

9. Birthplace Springs, Pa.
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Farm & Lumber

FATHER
12. Name John Stevanus
13. Birthplace Springs, Pa.

MOTHER
14. Maiden name Elizabeth Yoder
15. Birthplace Meyersdale, Pa.

16. Informant Ralph E. Stevanus
Address Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof August 17, 1945 (month) (day) (year)

Cemetery or crematory Mennonite Cemetery

Location Springs, Pa.

18. Funeral director John J. Hofer

Address Confluence, Pa.

19. Aug 17 1945 M. G. Vanmeter
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 14 1945 at 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12 1942, to August 14 1945

and that I last saw h... alive on August 2 1945

	DURATION
Immediate cause of death: congestive heart failure	2 Months
Due to: Chronic myocard'tis	3 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L Brings MD
M. D. or other

Address Cumberland, Md Date signed 8-16-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

07657

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, Institution, or street address where death occurred: 172 Virginia Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn Infants give residence of mother)

State Maryland County Allegany

City or town Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 172 Virginia Ave. (If rural, give LOCATION)

2.(a) If veteran, name war —

3. (a) FULL NAME Anna Cora Davis Storer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~ Harry Storer

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 4 1867

8. AGE: Years	Months	Days	If less than one day
77	7	27	..... hrs. ..... min.

9. Birthplace Vale Summit Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business At Home

FATHER 12. Name James L. Davis

FATHER 13. Birthplace Pa.

MOTHER 14. Maiden name Minnie Wagner

MOTHER 15. Birthplace Ohio

16. Informant Mrs John Pasko

Address Cumberland

17. Burial (Burial, cremation, or removal—Which?) Date thereof Aug 4 '45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Aug. 4 1945 Walter R. Frantz M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 1 1945 at 9 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1945 to Aug 1st 1945 and that I last saw h[er] alive on Aug 1st 1945

Immediate cause of death	DURATION
(a) Myocarditis	2 yrs
Due to (b) Hypertension	several years
Due to (c)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE C. E. Dwen M.D. M. D. or other

Address Cumberland Md Date signed 8-3-45

WITHIN CORPORATE LIMITS
DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07658

CERTIFICATE OF DEATH

★ Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? # 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town ELLERSLIE
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME CATHERINE STUBY

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife HENRY STUBY
6.(c) If alive, give age 29 years
7. Birth date of deceased (mo., day, yr.) JAN. 4th, 1916

8. AGE: Years	Months	Days	If less than one day
29	7	3	hrs. min.

9. Birthplace Ellerslie Md (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name WILLIAM HOWARD
13. Birthplace PA.

MOTHER
14. Maiden name EDITH WATTS
15. Birthplace PA.

16. Informant Mrs. Henry Stuby
Address Ellerslie, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug. 10, 1945 (month) (day) (year)
Cemetery or crematory Medley Cem.
Location Medley, Pa
18. Funeral director Harvey N. Zeigler
Address Hyndman, Pa.
19. Aug 9, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH AUG. 7, 1945, at 5:05 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 6 1945, to Aug 7 1945
and that I last saw h 7 alive on Aug 7 1945

Immediate cause of death	DURATION
Generalized peritonitis,	
Due to Gangrene of intestine,	
Due to Criminal abortion	4 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Gangrenous small intestines Date of op. Aug 6, 1945
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. M. Wilson M.D. M. D. or other
Address Cumberland Md Date signed 8-9-45

MARGIN RESERVED FOR BINDING
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.
VS A15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

07659

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 days

Hospital, Institution, or street address where death occurred: Miners' Hospital

How long in hospital or institution? 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland (If outside city or town limits, write RURAL and give nearest town)

Street No.: Paradise Road (If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Margaret Udora Tighe

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas Tighe

6.(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Jan. 15, 1870

8. AGE: Years 75 | Months 7 | Days 5 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Cresaptown, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER

12. Name: Isaac Stevenson

13. Birthplace: United States

MOTHER

14. Maiden name: Diana Mertz

15. Birthplace: Germany

16. Informant: Mrs. Walter Rose

Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 22, 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: Dr. Eichhorn

Address: Lonaconing, Md.

19. 8-22 (Date rec'd by registrar) 19— Mrs. Harvey L. Rex Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 19 1945 at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1945, to Aug 19 1945 and that I last saw her alive on Aug 19 1945

Immediate cause of death	DURATION
Typhoid Fever	Several weeks
Due to:	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.: ____

Autopsy results: ____

PHYSICIAN: Please underline the cause tn which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of: ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?): ____

Means of injury: ____ Injured at work?

23. SIGNATURE: W. M. Lane M.D. M. D. or other

Address: Frostburg, Md. Date signed: Aug 21 1945

WITHIN CORPORATE LIMITS

dr DR ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

CERTIFICATE OF DEATH

07660

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 465 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD County ALLEGANY

City or town CUMBERLAND, MD
(If outside city or town limits, write RURAL and give nearest town)

Street No. 17 FIFTH ST
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

mrs MRS ANNA TWIGG

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife PRESTON TWIGG

6.(c) If alive, give age 62 years

7. Birth date of deceased (mo., day, yr.) July 17, 1860

8. AGE: Years	Months	Days	If less than one day
85	0	20	...hrs. ...min.

9. Birthplace MD
(Town, county, and state)

10. Usual occupation HOUSEWIFE

11. Industry or business

FATHER
12. Name THOMAS SYBOLD
13. Birthplace W. Va.

MOTHER
14. Maiden name EMMA STECKMAN
15. Birthplace W. Va.

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 8, 1945 (month) (day) (year)

Cemetery or crematory Zion Memorial Park

Location Cumberland, Md. Bedford Rd.,

18. Funeral director Charles L. George
Address Cumberland, Md.

19 Aug 7 1945 Walter R. Tantz, M.D. Registrar
(Date received by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 6 1945, at 5:45a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ...19..., to ...19...

and that I last saw h... alive on ...19...

	DURATION
Immediate cause of death	
Diabetes Mellitus	Several yrs
Due to	
Due to	
Arteriosclerosis	several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D. M. D. or other

Address Cumberland Md. Date signed 8-6-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 75

07661

CERTIFICATE OF DEATH ★

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Race St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Arminta Francis Valentine

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Wm A. Valentine

6.(c) If alive, give age 31 years

7. Birth date of deceased (mo., day, yr.) July 28, 1913

8. AGE:

Years	Months	Days	If less than one day
32	0	4	hrs. min.

9. Birthplace Meyersdale, Somerset Co. Pa (Town, county, and state)

10. Usual occupation Floor Girl in Finished Fabric

11. Industry or business Celanese Corp.

FATHER 12. Name Clayton S. Eaton

FATHER 13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Anna E. Hersh

MOTHER 15. Birthplace Meyersdale Pa.

16. Informant Clayton S. Eaton

Address 9 Race St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 5 1945 (month) (day) (year)

Cemetery or crematory Hillcrest Cemetery

Location Cumberland, Md.

18. Funeral director John J Hafer

Address Cumberland Md.

19. Aug 4 1945 (Date rec'd by registrar) White K. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 2nd., 1945 at 4:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Cystic Spleen, Gangrenous.	about 10 days
Due to	
Due to	
Other conditions (Hemoglobin 52% at time of operation)	

(Include pregnancy within 3 months of death)

Major findings of operations Splenectomy 7-28-45

Gangrenous Cystic Spleen Date of op.

Autopsy results verified, as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Russell H. Boyson, M.D. M. D. or other

Address Cumberland, Maryland Date signed 8-4-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 07662

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 135 Washington St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 135 Washington
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Andrew Roy Watson

3.(b) Social Security Number: 213-09-6596

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 2 - 1884

8. AGE:

Years	Months	Days	If less than one day
61	2	0	hrs. ..... min.

9. Birthplace: Ellerslie - Allegany - Md.
(Town, county, and state)

10. Usual occupation: Timber

11. Industry or business: Allegany Ballistics Corp

FATHER — 12. Name: John H. Watson

13. Birthplace: Scotland

MOTHER — 14. Maiden name: Sarah Clancy

15. Birthplace: Scotland

16. Informant: Hugh Watson

Address: Frostburg, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 11-1945 (month) (day) (year)

Cemetery or crematory: Ellerslie

Location: Ellerslie, Md.

18. Funeral director: J. B. Durst

Address: Frostburg, Md.

19. 8-4 1945 (Date rec'd by registrar) Harvey A. Poe, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 2 1945, at 4 00 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 1 1945, to Aug 2 1945, and that I last saw b[illegible] alive on July 31 1945

Immediate cause of death	DURATION
Coronary Thrombosis	Sudden
Due to: Hypertension	4 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: Wm. Lane Jr. M.D. (M. D. or other)

Address: Frostburg, Md. Date signed: 8-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

07663

★ Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 Years

Hospital, Institution, or street address where death occurred:
221. Emily St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 221. Emily St
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Jennie V. Webb

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Joseph W Webb

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): September 20 1870

8. AGE: Years	Months	Days	If less than one day
74	10	14	..... hrs. ..... min.

9. Birthplace: Harpers Ferry, Jefferson Co, W. Va.
(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER
12. Name: Arron Staubs
13. Birthplace: W est Virginia

MOTHER
14. Maiden name: Mary Nicewaner
15. Birthplace: West Virginia

16. Informant: Mrs Jessie Hawks

Address: 221. Emily St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8/7/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Aug 7 19 45 Victor F. Swartz M.A. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 4 1945, at 4-30A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 4 1945 to Aug 4 1945 and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Chr Hyp of Carditi	1 yr
Due to	
Due to Hypertension + Arteriosclerosis	several years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of ...

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J L Owens M D
M. D. or other

Address: Cumberland Md Date signed 8-4-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (930)

CERTIFICATE OF DEATH

07664

★ Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs.
Hospital, institution or street address where death occurred:
413 Prince George St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 413 Prince George St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Abra D. Whitehair

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Elizabeth Thompson
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 24 1885

8. AGE: Years	Months	Days	If less than one day
59	7	8	..... hrs. ..... min.

9. Birthplace: Circleville W. Va.
(Town, county, and state)
10. Usual occupation: Station Master
11. Industry or business: B & O Ry — Retired 12 yrs
FATHER 12. Name: Granville Whitehair
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Ambrose
15. Birthplace: "
16. Informant: Raymond F. Whitehair
Address: Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 4 1945 (month) (day) (year)
Cemetery or crematory: St Mary's Cem
Location: Cumberland Md
18. Funeral director: Louis Stein Sons
Address: Cumberland Md
19. Aug 4, 1945 (Date rec'd by registrar) Winter R. Mantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug 1 1945 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 to Aug 1, 1945 and that I last saw h... alive on July 15 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	Sudden
Due to: Hypertension and Cardio Vascular Lesions	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jean R. Furnes M. D.
Address: Cumberland Date signed: Aug 3, 1945

DR JACOBSON

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 30

07665

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 14 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town CUMBERLAND, MD
(If outside city or town limits, write RURAL and give nearest town)
Street No. 822 COLUMBIA AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME MR ALVA D. WILKINS

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ELIZABETH R. SHAW

6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) AUGUST 20, 1878

8. AGE: Years	Months	Days	If less than one day
67	0	10	...hrs. ...min.

9. Birthplace Dola W.VA
(Town, county, and state)

10. Usual occupation UNABLE TO WORK

11. Industry or business

FATHER
12. Name DANIEL WILKINS
13. Birthplace W.VA

MOTHER
14. Maiden name Katherine Green
15. Birthplace W.VA

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 9/2/45 (month) (day) (year)
Cemetery or crematory Hill Crest Cemetery
Location Cumberland, Md.

18. Funeral director William H. Kight
Address Cumberland, Md.

19. Sept 1, 1945 Walter R. Brant M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH AUGUST 30, 1945 at 10:55 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 16 1945 to Aug 30 1945 and that I last saw him alive on Aug 30 1945

Immediate cause of death	DURATION
Anuria	5 days
Due to Cerebral Hemorrhage	15 days
Due to cerebrospinal syphilis	?
Other conditions Pernicious Anemia	?

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Samuel Jackson M.D. M. D. or other
Address 151 S. Lee St. Date signed 8/31/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

WITHIN CORPORATE LIMITS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

07666

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 53 yrs

Hospital, institution, or street address where death occurred:

605 N. Centre St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 605 N Centre St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Harold L. Wilson

3.(b) Social Security Number 214-12-3281

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret Himmler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 9 1892

8. AGE: Years 53 | Months 4 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Auto Mechanic

11. Industry or business

FATHER 12. Name Isaac Wilson

13. Birthplace Md.

MOTHER 14. Maiden name Susan Roberts

15. Birthplace Md.

16. Informant Mrs Margaret H Wilson

Address Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 7 45 (month) (day) (year)

Cemetery or crematory St Peters Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Aug 7 1945 (Date rec'd by registrar) Winter L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5 1945, at 3 30 P.M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 2 1945, to Aug 5 1945

and that I last saw h alive on Aug 2 1945

Immediate cause of death	DURATION
Hemorrhage Carcinoma	2 wks
Due to Hypernephroma Carcinoma	6 mos
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Cumberland Md Date signed Aug 6 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15